| ` '   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b> |   | (X3) DATE SURVEY<br>COMPLETED              |  |  |  |
|---|--|--|--|---|--|--|--|--|
| FCL051050   |  | B. WING  |  |   | 02/18/2016                                 |  |  |  |
| NAME OF F   | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |  |  |   |  |  |  |  |
| ULTIMATE FAMILY CARE HOME # 4 144 BIG PINE ROAD CLAYTON, NC 27520 |  |  |  |   |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  |  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY) | E ACTION SHOULD BE<br>D TO THE APPROPRIATE |  |  |  |
| C 000   | Initial Comments   |  | C 000  |   |  |  |  |  |
|   | Report by Suzanna  | Fay and Randy Julian   |  |   |  |  |  |  |
|   | Survey on February 4:15 PM at the above records indicate the February 21, 2012 a five ambulatory Respond without any during a fire or other information we are compliance with the 10A NCAC 13G for 2009 North Carolina Section 421.2 - Research | a Section conducted a Biennial vi 18, 2016 from 3:15 PM to we referenced facility. DHSR home was first licensed on as a Family Care Home for sidents (able to evacuate and y physical or verbal assistance or emergency.) Based on this requiring the home to maintain a following: the 2005 Rules Family Care Homes and the a State Building Code sidential Care Homes.  sit, we cited deficiencies that one plan of correction. They |  |   |  |  |  |  |
| C 117   | Have Current San.  | And Fire Safety Approvals  | C 117  |   |  |  |  |  |
|   | fire and building saf  |  |  |   |  |  |  |  |
|   | not have copies of t<br>Inspections at the fa<br>current Fire and Sa<br>Provide copies of th<br>Sanitation Inspection  | ds revealed that the facility did<br>the current Fire and Sanitation<br>acility. Maintain copies of the<br>nitation reports at the facility.<br>he most recent Fire and  |  |   |  |  |  |  |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>  |                     | (X3) DATE SURVEY<br>COMPLETED  |            |                          |  |  |
|---|--|---|---------------------|--|------------|--------------------------|--|--|
| FCL051050   |  |   | B. WING             |  | 02/18/2016 |                          |  |  |
| NAME OF F   | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |   |                     |  |            |                          |  |  |
| ULTIMATE FAMILY CARE HOME # 4 144 BIG PINE ROAD CLAYTON, NC 27520                                   |  |   |                     |  |            |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE       | (X5)<br>COMPLETE<br>DATE |  |  |
| C 147   | SECTION .0300 - T 10A NCAC 13G .03 AND EXITS (d) All exit door loo by a single hand mo times without keys. buttons on the insid removed or disable.  This Rule is not me 1. Observations re door hardware was qualified technician with single action had documentation of the | cks shall be easily operable, otion, from the inside at all Existing deadbolts or turn le of exit doors shall be d.  et as evidenced by: vealed that the kitchen exit not single action. Have a replace the door hardware ardware. Provide ne correction in the form of | C 147               |  |            |                          |  |  |
| C 152   | smooth, non-skid m<br>to be easily cleanab<br>(b) Scatter or throw<br>(c) All floors shall I<br>This Rule is not me<br>1. Observations rea<br>at the threshold bet<br>Bedroom. Have a co<br>floor. Provide docu  | and FLOORS  amily care home shall be of laterial and so constructed as ole.  w rugs shall not be used. be kept in good repair.  | C 152               |  |            |                          |  |  |
| C 174   | ·  | Maintained Safe, Operating  | C 174               |  |            |                          |  |  |

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Division of Health Service Regulation STATE FORM

6WTH21 If continuation sheet 2 of 4

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SU   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b> |   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|---|---|-----------------------------------|-------------------------------|--|
| FCL051050   |  | B. WING  |  | 02/   | 02/18/2016  |                                   |                               |  |
| NAME OF P   | PROVIDER OR SUPPLIER   |  | STREET AD  | DRESS, CITY, S                                    | STATE, ZIP CODE   |                                   |                               |  |
| ULTIMATE FAMILY CARE HOME # 4 144 BIG PIN CLAYTON,  |  |  |  |   |   |                                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIE<br>MUST BE PRECEDE<br>SC IDENTIFYING INF   | ED BY FULL   | ID<br>PREFIX<br>TAG                               | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| C 174   | Continued From part 10A NCAC 13G .03 EQUIPMENT  (a) The building at mechanical, and plucare home shall be operating condition  (j) This Rule shall family care homes.  This Rule is not med. Observations rehandrails and rampinjury. Hammer the smooth and level standoumentation of the photos or work order.  2. Observations remissing from the freglobe. Provide dood the form of photos.  3. Observations reoutlet to the right of and would not reserve repair or replace the documentation of the receipts or work order.  4. Observations remelted the plastic fixture at the back of the technician repair the fixture at the back of the technical repair the technical r | and all fire safety, umbing equipme maintained in a apply to new an et as evidenced vealed nails pope surface. Provide ne repairs in the ers.  vealed that the gont porch light firm umentation of the process of the back deck was a qualifier outlet. Provide the back deck was a qualifier outlet. Provide the repairs in the ders.  vealed that the set outlet. Provide the back deck was a qualifier outlet. Provide the event of the back deck was a qualifier outlet. Provide the event of the back deck was a qualifier outlet. Provide the property in the ders.  vealed that the set of the provided and that the set outlet. Have a qualifier outlet and insome repairs in the work orders. | by: poping up on the could cause provide a form of globe was atture. Install a ne repairs in exterior GFCI was tripped ied technician e form of coulb had prior light alified tall a properly e. Provide form of | C 174   |   |                                   |                               |  |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING: | 00   |                                | E SURVEY<br>PLETED       |  |  |  |
|---|--|--|------------------------------|--|--------------------------------|--------------------------|--|--|--|
| FCL051050   |  | B. WING  |                              | 02/  | 02/18/2016                     |                          |  |  |  |
| NAME OF   | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE |  |                              |  |                                |                          |  |  |  |
| ULTIMATE FAMILY CARE HOME # 4 144 BIG PINE ROAD CLAYTON, NC 27520 |  |  |                              |  |                                |                          |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |  |  |
| C 174   | Continued From pa  | ige 3  | C 174                        |  |                                |                          |  |  |  |
|   | of the repairs in the  | e form of photos.  |                              |  |                                |                          |  |  |  |
|   | the Staff room and<br>should be placed in<br>prevent the tanks fr  | evealed oxygen tanks stored in in Bedroom 1. Oxygen tanks in secure storage bins to from tipping or falling over. ation of the repairs in the form |                              |  |                                |                          |  |  |  |
|   | 7. Observations re loose board at the l                            | evealed a broken chair and a back of the facility. Remove documentation of the repairs os.   |                              |  |                                |                          |  |  |  |
|   |  |  |                              |  |                                |                          |  |  |  |

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